Maryland Child Fatality Review

Child Fatality Review is a systematic, multi-agency, multi-disciplinary review of unexpected child deaths. This review process, which began in Los Angeles in 1978 as a mechanism to identify fatal child abuse and neglect, has grown into a national system to examine child fatalities within the context of prevention. Child Fatality Review (CFR) was established in Maryland in 1999 (Health-General Article, §5-701-709, Annotated Code of Maryland). The 25 member State CFR Team comprises representatives of 12 State agencies or offices, two pediatricians with expertise in child maltreatment and 11 members of the general public with interest and expertise in child safety and welfare who are appointed by the Governor. The State CFR Team is housed within the Department of Health and Mental Hygiene (DHMH) for budgetary and administrative purposes.

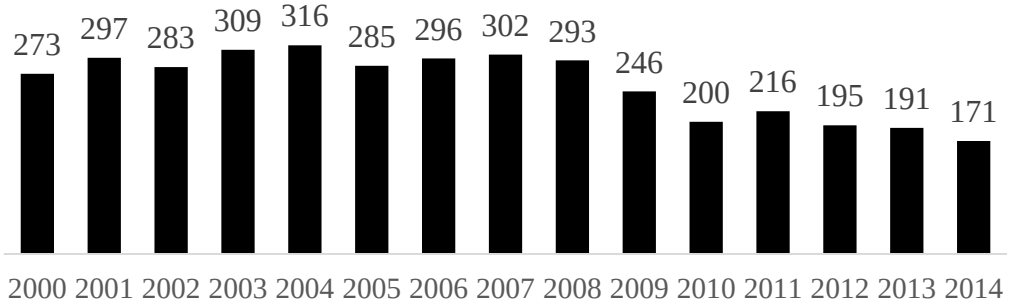
The purpose of the State CFR Team is to prevent child deaths by:
(1) understanding the causes and incidence of child deaths; (2) implementing changes within the agencies represented on the State CFR Team to prevent child deaths; and (3) advising the Governor, the General Assembly and the public on changes to law, policy and practice to prevent child deaths. The State CFR Team meets at least four times a year and provides an annual report to the Governor (available at http://phpa.dhmh.maryland.gov/mch/SitePages/cfr-home.aspx).

The State CFR Team oversees the efforts of local CFR Teams that operate in each jurisdiction. Local CFR teams are given notice of unexpected resident child deaths each month by the Office of the Chief Medical Examiner (OCME) and are required to review each of these deaths. The manner of these deaths is determined to be either natural, homicide, suicide, accidental or undetermined. Local teams then make recommendations for local level systems changes in statute, policy or practice, and work to implement these recommendations.

The number of child fatality cases reported by the OCME to local teams for review is shown below:

Figure 1. Number of OCME Child Fatality Review Referrals in Maryland, 2000 - 2014

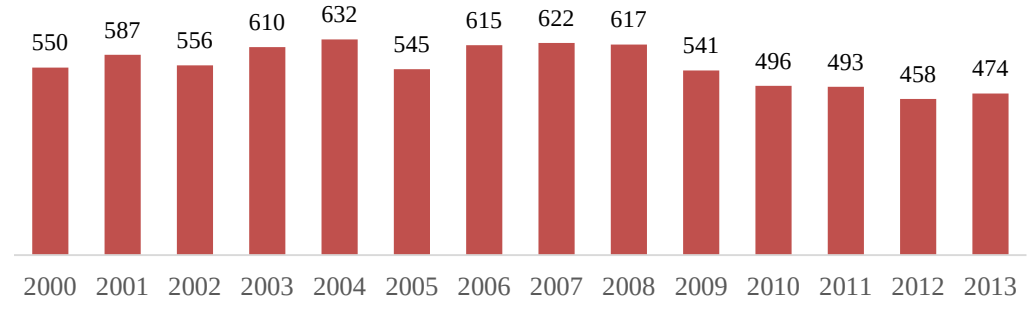
Total number of referrals = 3,873



Souce: OCME Referral Tracker as of 12/3/2014

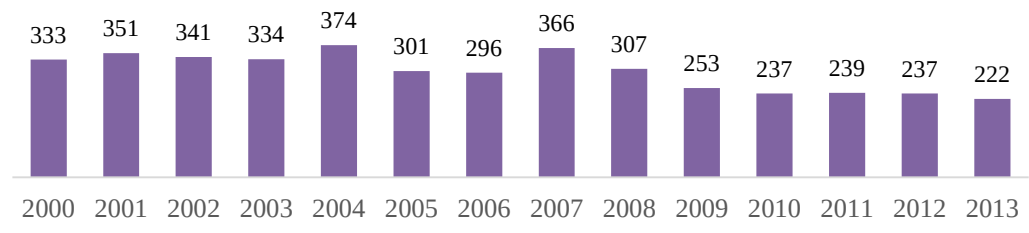
Figure 1 shows that the number of unexpected deaths referred for Child Fatality review has declined from 2008 to 2013. A decline is similarly seen in overall infant deaths (under one year of age) and child deaths (ages 1 to 17) during the same period (figures 2 and 3 respectively).

Figure 2. Number of Infant Deaths (age <1 year) in Maryland, 2000 - 2013



Souce: MD Vital Statistics Administration

Figure 3. Number of Child Deaths (1-17 years) in Maryland, 2000 - 2013



Souce: MD Vital Statistics Administration

Comparing the 3 year period from 2007-2009 with the period from 2010-2012, infant deaths from sudden infant death syndrome and sudden unexpected infant death have decreased. Among children age 1 to 17, deaths due to unintentional injury, homicide, and suicide have also all decreased in the 2010-2012 period (Table 1). Deaths from all of these causes are included in referrals from the OCME for Child Fatality review. The declines in deaths from these causes contribute to the decrease in OCME referrals seen in recent years.

Table 1. Number infant & child deaths by cause for 3 year time periods.

Category	2007-2009	2010-2012	# Change	% Change
Causes of infant death (< 1 year old)				
SIDS	197	141	-56	-28.4
SUIDS	231	178	-53	-22.9
Other causes	1,352	1,128	-224	-16.6
Total infant deaths	1,780	1,447	-333	-18.7
Causes of child death (1-17 years old)				
Unintentional injury	262	188	-74	-28.2
Homicide	141	77	-64	-45.4

Suicide	49	43	-6	-12.2
Other causes	474	405	-69	-14.6
Total child deaths	926	713	-213	-23.0

SIDS: sudden infant death syndrome SUIDS: sudden unexpected infant deaths

Deaths referred for Child Fatality review from 2000-2014 are further analyzed by age, gender, race and manner of death distribution in figures 4 through 11 below.

Figure 4. Number of OCME Child Fatality Review Referrals in Maryland, 2000 - 2014, by Age Group

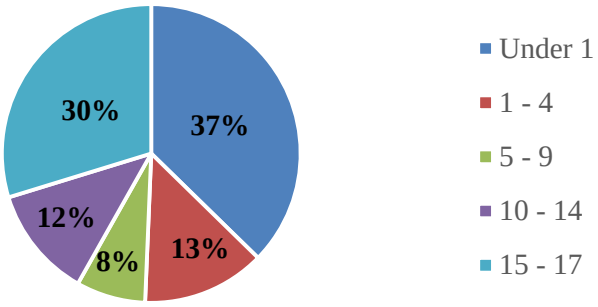


Figure 5. Number of OCME Child Fatality Review Referrals in Maryland Time Period and Age Groups.

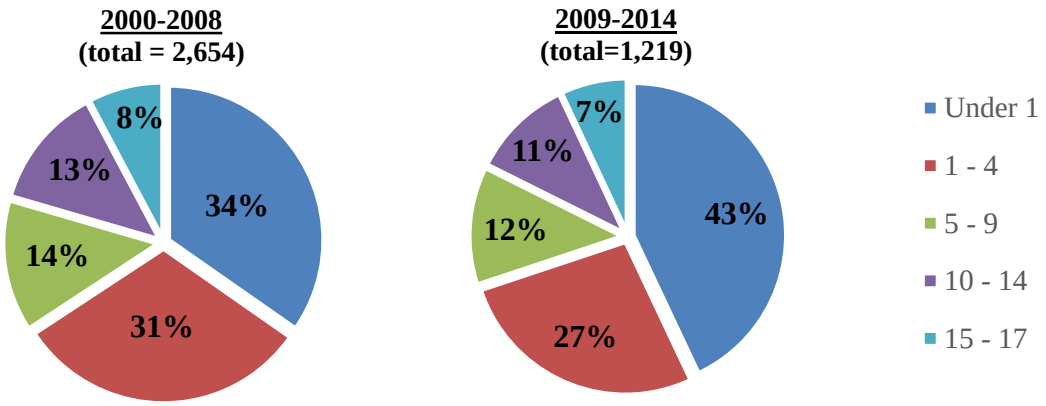


Figure 6. Number of OCME Child Fatality Review Referrals in Maryland, 2000 - 2014, by Gender

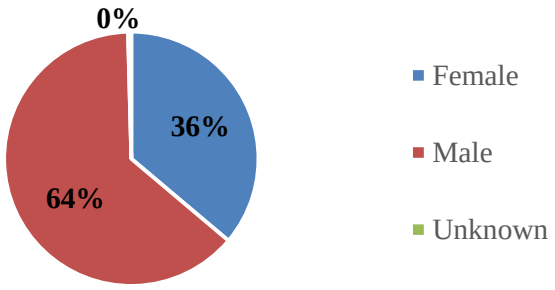


Figure 7. Number of OCME Child Fatality Review Referrals in Maryland by Time Period and Gender.

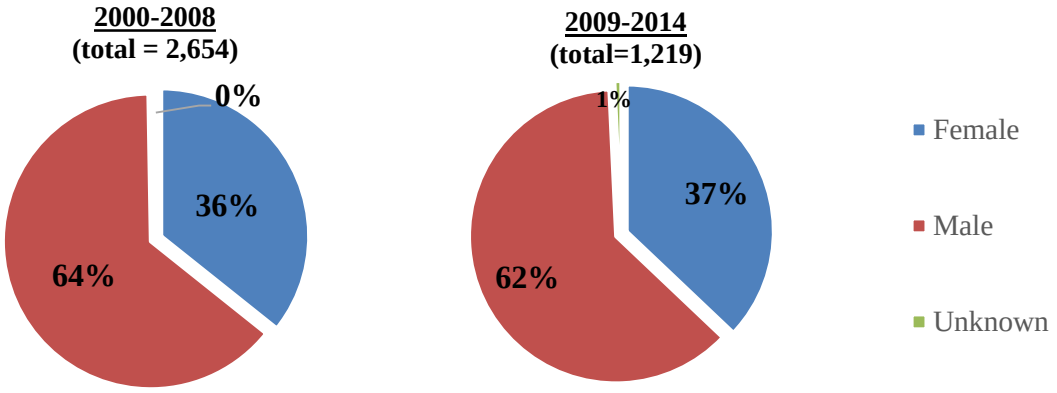


Figure 8. Number of OCME Child Fatality Review Referrals in Maryland, 2000 - 2014, by Race

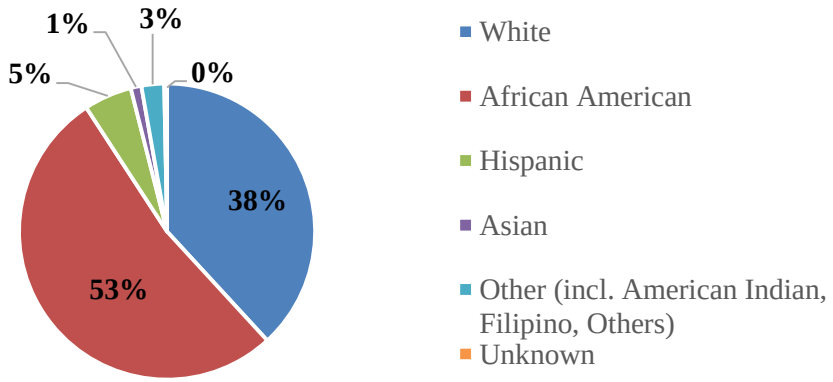


Figure 9. Number of OCME Child Fatality Review Referrals in Maryland by Time Period and Race.

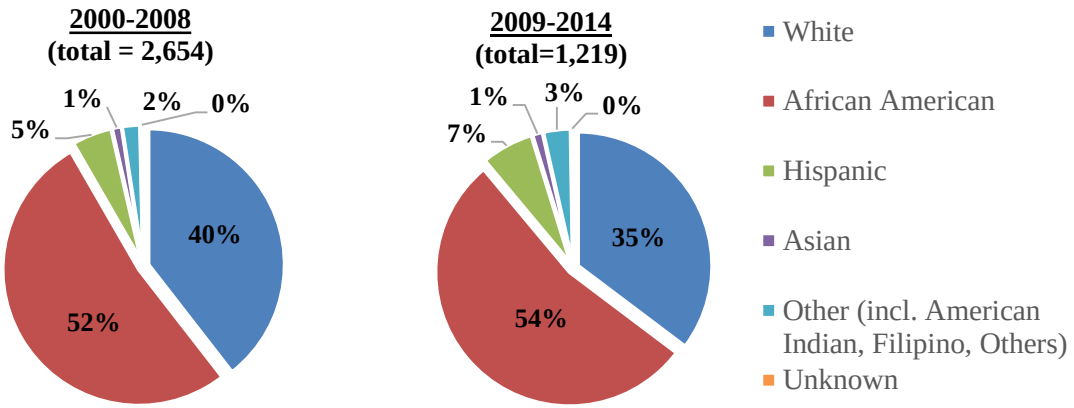


Figure 10. Number of OCME Child Fatality Review Referrals in Maryland, 2000 - 2014, by Manner of Death

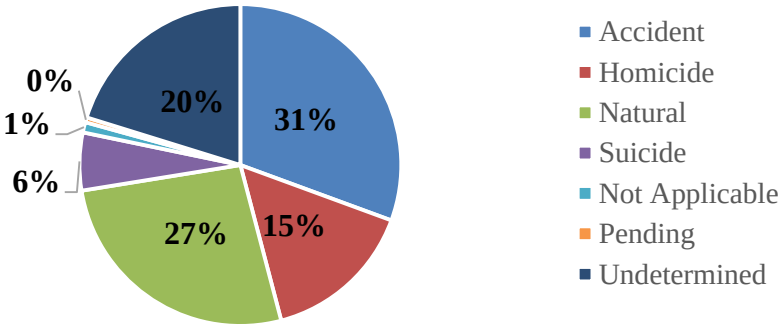


Figure 11. Number of OCME Child Fatality Review Referrals in Maryland by Time Period and Manner of Death.